



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

IN REPLY REFER TO

BUMEDINST 1001.4
BUMED-07
12 Jul 2002

BUMED INSTRUCTION 1001.4

From: Chief, Bureau of Medicine and Surgery
To: Ships and Stations Having Medical Department Personnel

Subj: NAVY MEDICINE RESERVE UTILIZATION PROGRAM

Ref: (a) SECNAVINST 1001.37A
(b) OPNAVINST 1001.23
(c) SECNAVINST 5214.2B

Encl: (1) MOU between Chief Bureau of Medicine and Surgery, Commander Naval Reserve Force, and Commander Naval Surface Reserve Force of 5 Nov 2000
(2) Validation of Requirements
(3) Workflow Process for MEDRUPMIS

1. Purpose. To provide revised policy guidance and assign responsibilities to ensure the effective integration, utilization, and training of claimancy 18 Reserve medical and dental personnel. Claimancy 18 is comprised of Naval Reserve Naval Hospitals (NRNH), Naval Reserve Fleet Hospitals (NRFH), and Naval Reserve Dental Commands (NRDC).

2. Background

a. The mission of the medical Reserve has expanded from a traditional mobilization role to support of the full spectrum of Navy Medicine's requirements. Current national military strategy calls for seamless integration of the Active and Reserve components into a total force as directed in reference (a).

b. The Navy Surgeon General is the resource sponsor for claimancy 18 medical Reserve programs. This includes eight NRNHs, four NRFHs, and 11 NRDCs. The resource sponsor procures resource funding, establishes Reserve billet requirements, and determines budgetary objectives for medical programs to meet operational plans and peacetime contributory support requirements.

c. Effective 5 November 2000, per enclosure (1), operational control of the NRNHs, NRFHs, and NRDCs was transferred from Commander, Naval Surface Reserve Force to Bureau of Medicine and Surgery (BUMED) to implement total force integration. The Medical Reserve Utilization Program (MEDRUP) is BUMED's plan to implement "One Navy Medicine."

3. Policy

a. The Navy Surgeon General is responsible for medical readiness of the total force. Navy Medicine, using both Active Component (AC) and Reserve Component (RC) assets, will provide medical and dental readiness support to the Naval and Marine Corps Reserve Force.

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b. The Assistant Chief for Reserve Force Integration, BUMED (MED-07), is responsible for operational policy guidance and oversight of Reserve medical and dental programs. This includes medical readiness, force health protection, health promotion, professional training, Reserve utilization, medical selected Reserve (SELRES) retention, accuracy of billet assignments and manning documents, and management of the claimancy 18 Reserve liaison officer (RLO) and enlisted medical Training and Administration of Reserve (TAR) Programs. BUMED (MED-07) is also responsible for implementation of Navy Medicine's MEDRUP and deployment of the automated management information system that supports this program, the Medical Reserve Utilization Program Management Information System (MEDRUPMIS).

c. Claimancy 18 medical SELRES are members of the Navy Medical Department functioning as part time staff in support of the mission of Navy Medicine. In today's world of reduced resources and increased commitments, it is essential that the investment in Reserve forces be used efficiently and effectively. The medical Reserve must focus on opportunities that fully utilize the skills and qualifications of the SELRES members to support the Navy's needs and mission requirements. Utilization is not limited to the assigned medical or dental treatment facility (MTF or DTF) or fleet hospital platform. Reference (a) requires that trained and qualified reservists are available for assignment throughout the entire spectrum of requirements, including war or national emergency, contingency operations, military operations other than war, peacetime contributory support (PCS), humanitarian operations, and at such other times as the national security may require. Medical department SELRES personnel will meet the same professional qualifications and train to the same standards as active duty personnel. Reserve members will train to meet the assigned platform requirements. Any additional training days or funding will be utilized for contributory support initiatives to ensure maximum support to the full spectrum of the Navy Medicine mission.

d. Integrated peacetime contributory support requires both Active and Reserve medical department personnel to have a flexible approach in utilization of Reserve medical SELRES. Reserve personnel must be available to meet peacetime contributory support requirements at times when they are most needed or when the best training is available. Flexibility in performing scheduled drill periods and annual training is critical in enabling SELRES to accommodate the needs of their designated MTF/DTF, fleet hospital platform and the global obligations of Navy Medicine.

e. Identification of contributory support needs, tracking of support delivered and overall management of the integration of the medical Reserve will be coordinated by BUMED (MED-07). Medical requirements will be identified in advance to the greatest extent possible and medical SELRES will be requested to support a requirement for which they are qualified via their chain of command. This is not limited to annual training (AT), and may include active duty for training (ADT) or active duty for special work (ADSW). Assignments will not necessarily be at the members parent command.

f. The Commander, Naval Reserve Force (CNRF) and Commander, Naval Reserve Forces Command (CNRFC) will continue to provide administrative support to the Medical Reserve

units. Using existing infrastructure, the Naval Reserve Force will continue to be responsible for administrative systems including order writing, billet assignments, pay and benefits, travel, disability processing, medical record management, physical fitness testing, drug screening, fitness report and evaluation processing, promotion and advancement, recruitment and mobilization.

4. Organization

a. NRNHs, NRFHs, and NRDCs shall each have a headquarters detachment consisting of a commanding officer (CO), executive officer, training officer, and other administrative and functional area directors required to manage the command. A national board process shall select the CO and all other non-command 05/06 positions. A headquarters detachment will serve as the central management organization for each of the NRNHs, NRFHs, or NRDCs, including all detachments for planning, support and communication. The headquarters is also the coordinating body with the active command and BUMED.

b. NRNHs, NRFHs, or NRDCs will be further organized into detachments with officers in charge (OICs) reporting to the parent NRNH, NRFH, or NRDC CO. The CO will be the reporting senior of the detachment OIC. Reserve centers and readiness commands may provide performance information memorandum (PIM) to the unit's reporting CO, however they are not responsible for regular or concurrent fitness reporting of NRNH, NRFH, NRDC COs or OICs per enclosure (1). Detachments shall communicate with the active duty commands via the NRNH, NRFH, or NRDC headquarters element or as directed by the headquarters.

c. NRNHs and NRDCs report to the designated parent MTF/DTF active duty COs. NRFHs report to the Deputy Surgeon General, BUMED. The Assistant Chief for Health Care Operations, BUMED (MED-03), provides oversight of all MTF assets and requirements for both AC and RC. NRNHs come under the cognizance of BUMED (MED-03). The Assistant Chief for Dentistry, BUMED (MED-06), has oversight responsibility for DTFs and the NRDCs. The Assistant Chief for Operational Medicine and Fleet Support, BUMED (MED-02), manages the consolidated Fleet Hospital Program consisting of 10 fleet hospitals, six ACs, and four RCs.

d. To maintain effective management, detachments generally shall not contain more than 75 or less than 20 members. COs shall review their detachments and recommend restructuring to BUMED (MED-07). COs will meet at least once a year with their detachment OICs. Metrics shall be established and monitored by BUMED (MED-07) to evaluate readiness, contributory support, training, and other performance indicators identified in the Reserve Force Integration Strategic Plan.

e. COs of NRNHs, NRFHs, and NRDCs shall attend two total force planning conferences per year, hosted by BUMED. One conference will include an invitation for the executive officer and command master chief. The NRNH, NRFH, and NRDC headquarters personnel are encouraged to attend the AMSUS Total Force weekend session each year.

f. NRNHs will be integrated into their parent MTF. Reserve COs should be included on MTF Executive Steering Committee and be represented by the RLO in activities when not available. NRDCs will be integrated into their respective naval dental commands (NDCs). NRDC COs should be included on the DTF Steering Committee. NRDCs will receive operational guidance from BUMED (MED-06) to effectively support annual dental requirements. NRFHs will receive all program guidance from BUMED (MED-02FH/27), the coordinating code for the Fleet Hospital Program.

5. Training

a. BUMED will oversee the establishment of medical and dental professional training requirements. BUMED (MED-76) will manage the continuing medical education funds, course quotas, and the selection process for the medical Reserve. COs will be responsible for identifying and approving unit members for training programs. Designated NRNH and NRFH training officers will coordinate with BUMED (MED-73) to ensure the approved applications are entered into the MEDRUPMIS. NRDC COs will coordinate with BUMED (MED-67) to ensure the approved applications are entered into the MEDRUPMIS.

b. Reserve unit and individual training will meet the same standards as the active duty. NRNH, NRFH, and NRDC COs will prepare AT plans, and prioritize training evolutions. These training plans will be submitted to BUMED (MED-76) for integration into the Medical Reserve Annual Training Program. NRNHs and NRDCs must compete for inactive duty training travel (IDTT) funds at their associated Naval Reserve activity. NRFHs will retain fenced IDTT for support of training. Both the Active and Reserve components are responsible for training Reserve personnel, to include billet qualifications and rating specific training. Reserve personnel shall, whenever possible, train in their environment of care and in support of doctrine. This may include field exercises, operational missions, or peacetime contributory support.

c. All medical RCs will utilize the platform individual training plans (ITPs), available via the Reserve Standard Training Administration and Readiness Support (RSTARS) system or the Navy Training Management and Planning System (NTMPS), when available, and input the members training readiness status on a regular basis in the RSTARS program. Billet requirements included on the ITPs are determined by the Office of the Chief of Naval Operations (OPNAV) and executed by BUMED. The AC and RC COs will have an opportunity to review the training requirements on a regular basis.

d. Reserve personnel assigned to NRNHs must meet the requirements of the assigned billet. They must be able to maintain MTF operations and all missions assigned to the MTF. SELRES medical personnel will match these billet requirements by Navy Officer Billet Classification (NOBC) and Navy Enlisted Classification (NEC). Where applicable, officers will match these billet requirements by subspecialty code (SSP) and/or additional qualification designator (AQD), or acceptable substitutions as specified by BUMED. While members must match to their assigned billets, this should not limit the training opportunities in which a reservist can

participate. NRRH reservists may also be called on to provide a wide variety of support including contributory support to Navy Medical Department activities where health care delivery needs are severely stressed (particularly outside of the continental United States (OCONUS)), deployment forward with fleet hospital and hospital ship platforms in place of their active duty counterpart, fleet and joint exercises, and other activities that support the mission of Navy Medicine.

e. Fleet hospitals will train to achieve their designated mission readiness. Training will provide support in an operational field environment, to include inside the continental United States (CONUS) and OCONUS missions. Training in medical or patient care skills should be considered at the larger MTFs. Additional training guidance will be directed via the Fleet Hospital Platform Manager, BUMED (MED-27), to include scheduling of classes at fleet hospital operations and training command (FHOTC) and preparation for operational readiness evaluation (ORE).

f. NRDCs support their assigned NDC, however they also have a primary mission of dental augmentation for the summer surge at the Naval Recruit Training Center, Great Lakes, and Marine Corps Recruit Depots in San Diego, CA and Parris Island, SC. Training as set forth in the ITPs, will address the requirements necessary to prepare the dental department personnel in deployment and post deployment processing, as well as direct care with operational platforms and at DTFs.

6. Medical and Dental Readiness

a. Navy Medicine has responsibility for the health and medical readiness of the Naval and Marine Corps Reserve Force within the limits prescribed by Congress. In collaboration with the Commander, Naval Reserve Force (via surface and air), plans will be developed to provide medical and dental readiness support, and to monitor and report medical readiness data for all Naval Reserve force personnel. Navy MTFs and DTFs will be used to the fullest extent possible to meet the individual medical readiness (IMR) guidelines prescribed by the Department of Defense (Health Affairs). The medical Reserve will continue to provide medical and dental examinations during drill periods at Naval Reserve activities or MTFs of opportunity. BUMED will develop plans in collaboration with the Naval Reserve force medical officer and Naval Reserve force dental officer to provide additional medical and dental readiness support to readiness commands (REDCOMS) that are unable to meet their requirements within existing resources. This may include use of special traveling medical and dental Reserve teams, other military service medical facilities, the Department of Veterans Affairs, or public health service facilities.

b. BUMED will assist the Commander, Naval Reserve Force in establishing a medical and dental readiness monitoring program with appropriate standards, and an automated information system. These initiatives will require a close working relationship with the REDCOM directors of health services.

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7. MEDRUP Process

a. The evolution of the medical Reserve from a mobilization force to an integral part of the Navy Medical Department is a major cultural change for both Active and Reserve components. The purpose of the MEDRUP is to effectively utilize the medical Reserve to support the global requirements of the Navy Medical Department. To accomplish this mission, medical and dental requirements will be identified with sufficient lead-time to allow reservists to plan ahead. Centralized authority is required to validate and prioritize medical support requirements to ensure that Reserve resources are used where they are most needed. Once a requirement is identified, the MEDRUP process will match a qualified reservist to the assignment. To facilitate this process, BUMED has deployed an automated information system, known as MEDRUPMIS.

b. The MEDRUP process requires that active duty commands identify the projected medical support requirements by June for the following fiscal year. These requirements will have specific information about the number of reservist's required, medical skills, dates, and justification. For claimancy 18, MTF requests will be validated by BUMED (MED-31), NDC requests by BUMED (MED-06), and medical readiness support by BUMED (MED-07). All requirements for medical support outside of claimancy 18, including exercises, support to the commanders-in-chief (CINCs), the Marine Corps, joint operations, peacetime support, and other special interagency programs must be approved by OPNAV (N931). After approval by OPNAV (N931) the requirement will then be validated via the MEDRUPMIS and executed by BUMED (MED-27). Enclosure (2), validation of requirements, provides guidance on the approval authority for various types of requirements.

c. Validated requirements will be tasked to the Reserve unit CO to obtain appropriately skilled reservists for the assignment. NRNH, NRFH, and NRDC COs have the final authority to approve SELRES to the appropriate validated support or training requirement. The MEDRUPMIS will be the repository for assigned requirements and unit manpower. It will record assignment matches and produce standardized reports for management of the program. It is expected that assignment matching will be generally delegated to the detachment OICs. Once an assignment has been accepted, the member will complete the request for AT using Reserve force administrative process. Enclosure (3), workflow process for MEDRUP, outlines the workflow processes of deliberate planning, validation, and selection of a reservist to fulfill a requirement and provides a classification scheme for requirements based upon the original source of the requirement and authority for validation.

d. BUMED (MED-07) will monitor a global database to assess status of the program. If problems exist in obtaining qualified reservists to meet a command's validated requirements, BUMED (MED-07) will provide assistance.

e. An annual report will be prepared on medical Reserve utilization for the Navy Surgeon General and the Director of the Naval Reserve. This report will be presented at the AMSUS BUMED Total Force weekend session.

8. Medical RLO Program

a. The Assistant Chief for Reserve Force Integration, BUMED (MED-07) will be program manager for the RLO Program with responsibility for oversight and policy guidance for medical reservists serving in recall billets. BUMED (MED-07) will provide RLO training, opportunities for integration with other RLOs, management information, and support as required to successfully implement the Reserve initiatives of Navy Medicine.

b. Recalled reservists serving as MTF RLOs will have a reporting responsibility to the CO of their NRNH. NDCs and selected MTFs assign RLO responsibilities as a collateral duty of an active duty staff person. The success of the MEDRUP and support to the MTF will be dependent on the ability of the RLO staff to collect and enter requirements into MEDRUPMIS, and record command Reserve support that has been identified. This will require extensive coordination between the MTF, RLO, and the NRNH. Assets not attached to identified requirements shall be utilized where best determined by BUMED.

c. MTF and NDC RLOs will serve as representatives of their respective NRNH/NRDC CO to the MTF/NDC CO. They will serve in an advisory capacity on all Reserve matters to the command, as well as the point of contact for SELRES performing duty at the MTF/NDC.

d. Recalled Reserve RLOs shall not be assigned major collateral duties including plans operations medical intelligence (POMI) duties, disaster preparedness coordinator, or manpower manager. The responsibilities for coordination of the Reserve Administration and Training Program are the RLOs primary functions.

e. RLOs are responsible for the implementation of the MEDRUP management information system. Failure to activate the management information system will directly impact the ability of the command to obtain Reserve support. BUMED (MED-07) will provide technical assistance on a daily basis and assist visits upon request.

f. All medical department RLOs will receive policy guidance from BUMED (MED-07) and participate in regularly scheduled meetings and/or video-conferences. They are required to attend the AMSUS Total Force weekend session each year.

g. RLO responsibilities for training and administration of the medical Reserve should include: management of the MEDRUP management information system, assistance to the department heads and POMI in identifying Reserve requirements, notification to the professional affairs coordinator of SELRES providers scheduled to the MTF/NDC, confirmation of clinical privileges, maintenance of the billet control number system, coordination of orientation and training, assurance that reservists reporting to the command have adequate lodging, meals, and transportation, creation of welcome aboard packages, monitoring the usage and treatment of reservists, and initiation of corrective action when required, recording contributory support, assessment of satisfaction of both the command and the reservist, completion of fitness reports, professional appraisal reports and PIMs, and oversight of the SELRES catchment area immunization program. Reference (b) applies to RLO responsibilities.

h. The RLO should have a signature block on every command's checkout sheet. The RLO should interview each active duty member leaving active duty to provide information on the benefits of the Naval Reserve. This interview shall be developed in conjunction with the local Reserve recruiting commands to facilitate retention of trained medical personnel in the Naval Reserve.

9. MEDRUP Support for NRFHs

a. The NRFHs will utilize the MEDRUPMIS program to input training requirements or fill requirements for validated requests. The work flow process is outlined in enclosure (3). The fleet hospital program manager, assigned at the Reserve readiness command will facilitate the utilization and entries into the MEDRUPMIS Program.

10. Medical TAR Program

a. The Reserve Force Integration Master Chief, BUMED (MED-07E), will be responsible for community management and oversight of TAR corpsmen assigned to claimancy 18. TAR corpsmen shall be utilized for the purpose for which they were assigned to the claimancy, to support training and administration of the Reserve.

b. BUMED (MED-07E) will coordinate assignments of TAR enlisted personnel reporting to BUMED. Priority will be given to assignments supporting the MEDRUP. TARs will not be used to replace vacant active duty positions or to perform duties that do not support the training and administration of the Reserve.

11. Report Exemption. The reporting requirements included in this instruction are exempt from reports control per reference (c), part IV, paragraph G8.



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Available at: <http://navymedicine.med.navy.mil/instructions/external/external.htm>



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MEMORANDUM OF UNDERSTANDING
BETWEEN
CHIEF, BUREAU OF MEDICINE AND SURGERY
AND
COMMANDER NAVAL RESERVE FORCE
AND
COMMANDER NAVAL SURFACE RESERVE FORCE

Subj: OPERATIONAL CONTROL AND ADMINISTRATIVE SUPPORT OF NAVAL
SURFACE RESERVE UNITS ASSIGNED TO CLAIMANCY 18 PROGRAMS

1. Purpose. To delineate the responsibilities of Chief, Bureau of Medicine and Surgery (BUMED), Commander Naval Reserve Force (COMNAVRESFOR), Commander Naval Surface Reserve Force (COMNAVSURFRESFOR), and their subordinate commands for the operational control and administrative support of Reserve units assigned to Claimancy 18 Naval Reserve Naval Hospitals (Program 32), Naval Reserve Dental Augment Units, Naval Reserve Surgical Surge Units, and Naval Reserve Fleet Hospitals (Program 46).
2. Background. This Memorandum of Understanding (MOU) formalizes a process to fully integrate Reserve medical assets as an integral part of the Navy's Medical/Dental Force. This MOU establishes processes and organizational changes to allow implementation of a single, integrated Naval Medical Department. The primary goal is to integrate Reserve Program 32, 46, and Dental Augment Units into Medical/Dental Treatment Facilities (MTFs/DTFs), operational communities, BUMED and subordinate commands.
3. Expected Benefits. The most direct benefits will be to:
 - a. Enhance flexibility to respond to fleet commanders and parent command requirements.
 - b. Improve the overall efficiency and effectiveness for utilization of medical reserve forces.

Enclosure (1)

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c. Maximize medical/dental readiness for the Selected Reserve Force.

4. Delineation of Authority. This section specifies the authority over assigned Reserve Component (RC) forces that will be assumed by BUMED and its subordinate commands, and the authority that remains with COMNAVRESFOR and its subordinate commands.

a. Coordinating Authority Successful implementation of this MOU is based on the delegation of authority from COMNAVRESFOR and COMNAVSURFRESFOR to BUMED who will act as Coordinating Authority for implementation of responsibilities shifted under the MOU.

b. Operational Control (OPCON) authorities over the RC Forces Assigned to BUMED

(1) Navy Medicine will continue to provide the medical readiness support they have traditionally provided the Surface Reserve Force through Programs 7, 9, 32, and 46. In conjunction with COMNAVRESFOR and COMNAVSURFRESFOR, BUMED will provide health services beyond Surface Reserve medical capabilities to maximize medical and dental readiness for the Reserve Force.

(2) The Assistant Chief, Reserve Force Integration (MED07), will be responsible for achieving full integration of medical reserves and will exercise Coordinating Authority, in collaboration with the Medical Reserve Flag Officers for Programs 32 and 46.

(3) Program 32 and Dental Augment Reserve Unit Commanding Officers (COs) regular reporting senior will be their parent MTF/DTF commander. Program 46 COs will report directly to BUMED as their regular reporting senior. Orders for Program 32, 46 and Dental Augment COs will specify this primary reporting relationship. Program 32, 46 and Dental Augment COs will exercise regular reporting senior authority over all of their detachment officers in charge (OICs) with Performance Information Memorandum (PIM) reports from the appropriate Naval Reserve Activity (NRA) CO.

(4) BUMED will continue responsibility for the training and readiness of assigned medical RC forces, including development and approval of Individual Training Plans (ITPs).

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Existing tracking and reporting systems at COMNAVRESFOR will continue to be utilized for monitoring training and readiness.

(5) BUMED will continue to advise COMNAVSURFRESFOR in matters relating to structuring Program 32, 46, and Dental Augment Reserve units billets and establishment/disestablishment, with desired location of medical/dental reserve units. Billet/body mismatches will be submitted to COMNAVSURFRESFOR for corrective action.

(6) BUMED will exercise direct responsibility and control over the planning, prioritization, and approval (location/activity) where training is performed and the obligation of training funds, specifically, Active Duty for Training (CME ADT), and Annual Training (AT). BUMED will provide ADT requests to a COMNAVRESFOR representative during annual ADT negotiations with the Fleet Commander In Chiefs (CINCs). BUMED will prioritize the use of these funds based on both training and Peacetime Contributory Support (PCs) requirements that cannot be met via the primary sources of training funds provided to Reservists. BUMED will continue to rely on COMNAVRESFOR, its subordinate commands, and their established accounting systems, for actual travel orders, airline ticketing, reimbursement, and travel claim liquidation, as required.

(7) BUMED, in conjunction with COMNAVRESFOR and COMNAVSURFRESFOR, will review, provide, and monitor Reserve Force medical/dental readiness. In addition, BUMED will be provided medical/dental readiness data by COMNAVRESFOR as required, to respond to higher authority. All commands affected by this MOU will be asked for increased efforts in monitoring, reporting, and feedback of lessons learned, and are expected to support this effort fully, based on these critical evaluation needs. In the case of readiness reporting, BUMED initially will utilize existing COMNAVRESFOR reporting systems. For PCs reporting, BUMED will use its own reporting system, providing those reports to COMNAVRESFOR as the sole PCs input from Programs 32 and 46. Fleet Hospitals will report readiness status in Standard Operational Readiness Training Systems (SORTS) to BUMED and COMNAVRESFOR.

(8) BUMED will conduct Medical Inspector General visits as necessary for Program 32 and 46 units as determined by the Medical Inspector General, BUMED-07, and COMNAVSURFRESFOR.

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c. Administrative Control (ADCON) authorities over the RC
Forces Assigned to BUMED.

(1) Commander, Naval Reserve Force and its subordinate commands will continue to provide the administrative support they have traditionally provided for the Reserve Medical Force assigned to Programs 32, 46 and Dental Augment Units. This will include reserve pay, mobilization, medical, dental, and physical readiness, drug and alcohol screening programs, completion of fitness reports (FITREPS) and evaluations (except as specified elsewhere in this MOU), command assessment visits once every 3 years, retention, promotion and advancement, personnel records maintenance, order writing, and training outside the realm of Medical Department Forces, i.e., General Navy Training, Leadership Continuum, Non-Prior Service Accession Course, participation in national selection boards and national training opportunities. Some existing Naval Reserve processes, i.e., for orders and travel, readiness reporting, will be utilized as a support service, even though decision authority for these matters will shift to BUMED. When reservists cannot drill with their parent command, reliance on local NRAs for support will continue, much as it exists today.

(2) Naval Reserve Activity COs will remain responsible for supporting and evaluating the performance for Medical Department Reserve unit COs/OICs on all matters of administration, readiness and training, as discussed above. Commander, Naval Surface Reserve Force and subordinate commands will issue orders to unit COs that specify the reporting relationships, and guidance to NRAs on proper handling of FITREPs and PIMs for Program 32 and 46 COS/OICS.

(3) Commander, Naval Reserve Force, working with the Fleet CINCs, Reserve Liaison Officers (RLOs), and Plans, Operations and Military Intelligence Officers (POMIs), will support efforts to create a fair-share allocation of discretionary training funds (ADT) to meet Naval Medical Department operational requirements.

d. ADCON responsibilities shared by Chief, Bureau of Medicine and Surgery and the Commander, Naval Reserve Force.

(1) The above delineation of responsibilities is neither exhaustive nor inflexible, as lessons are expected to be learned during implementation. As areas of uncertainty emerge regarding

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responsibility, Naval Medical Department leadership should resolve questions based on this criterion:

(a) ADCON should reside in the Active or Reserve chain of command, based on which has the greatest knowledge, capability, vested interest or specific responsibility established by regulations governing the function under review.

(b) BUMED, COMNAVRESFOR and COMNAVSURFRESFOR will jointly manage some functions primarily in manpower areas. For example, the senior officer detailing process will utilize the existing COMNAVSURFRESFOR selection process; however, BUMED will have the opportunity, prior to the board, to communicate recommendations to the senior board member to achieve overall community career management. Other functions shared between BUMED and COMNAVSURFRESFOR will include investigations, military justice, and awards and recognition. To jointly manage the Medical Reserve, there will be an exchange of electronic information between BUMED, COMNAVRESFOR and COMNAVSURFRESFOR.

5. Implementation. To achieve a smooth transition and optimal success in reserve utilization to support Navy Medicine and Operational Forces, an implementation plan will be developed and executed during the first year of the MOU. The support and use of this model is consistent with the Reserve Integration policy. This MOU will be reviewed and modified as needed, with approval of the signatory commands. After three years, the MOU and implementing guidance will be reviewed for any needed changes, and if none are made, will remain in effect until otherwise canceled.

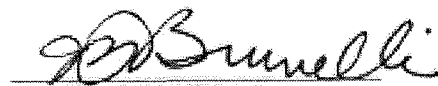
6. Effective date. 05 November 2000



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VALIDATION OF REQUIREMENTS

1. Non-Claimancy 18 Requirement. Requirements that originate outside claimancy 18 will be sent to OPNAV (N931). OPNAV (N931) validates and tasks the requirement to BUMED (MED-27). BUMED (MED-27) will conduct further validation, and task the requirement to BUMED (MED-07). BUMED (MED-07) will task a Reserve unit. Examples: CINC support of an exercise, Reserve center support for its administrative function, and 4th FSSG support by a Program 32 or 46 unit.
2. Exercise or Operations Requirement. Deployed with or to an exercise or operation, either CONUS or OCONUS. All of these requirements are validated through BUMED (MED-27). BUMED (MED-27) will take action following guidance from OPNAV (N931). After BUMED (MED-27) validates, BUMED (MED-07) will task a Reserve unit. Forward deployment of the reservist would qualify as this type of requirement. Performing backfill of an AC person with a RC person is classified below as an MTF or DTF requirement. In program 46, the FHOTC course qualifies as an exercise or operations requirement.
3. MTF Requirement. Work for a gaining command. The work directly contributes to the mission of the MTF. Replacing or adding to the staff of an MTF. All of these requirements are validated through BUMED (MED-31). If an MTF needs to draw reservists from outside their own coverage plan, then BUMED (MED-07) will review and re-task the requirement. BUMED (MED-07) will keep BUMED (MED-31) and the gaining command informed so as to monitor the potential for tasking to an AC.
4. Medical/Dental Readiness Requirement. Work to contribute to the readiness of the Reserve force at-large. All medical/dental readiness requirements are validated through BUMED (MED-07). Examples: Performing physical exams, performing some Reserve unit administrative functions, training other reservists, etc. It also includes any requirements that BUMED directs to flow through BUMED (MED-07) under special circumstances. As a general rule, all requirements for non-medical personnel are validated by BUMED (MED-07), and are therefore classified as medical/dental readiness, even though the name does not fit.
5. Training Requirements. Work to train the individual. This is typically a course of instruction or orientation. All of these requirements are validated through the Reserve unit CO or designee. Note: Detachment OICs are not authorized to validate these requirements unless they have received specific by direction authority.
6. DTF Requirement. Work for a gaining command. The work directly contributes to the mission of the DTF. Replacing or adding to the staff of a DTF. All of these requirements are validated through BUMED (MED-06).

WORKFLOW PROCESS FOR MEDRUPMIS

Classification Scheme for Requirements (classification identifies origination of need and authority for validation)

PROCESS	NON-CLAIMANCY 18	EX/OPS	MTF RQMT	COMMENTS ON MTF RQMT	MED DENT READY	TRAINING
Rqmt Conceived	Request to 931 and tasked MED-27	Generated by 931 and tasked to MED-27	RLO/Dept head/Res Unit to solicit and define	If generated by 931 and tasked to MED-31	RLO and REDCOM requirements plus all non-medical rqmts	NR CO OIC/TO
Pre-MEDRUP	MED-27 review and task to Res Unit	MED-27 review and task to MED-07 for Program 32 or a Fleet Hospital for Program 46	Optional exchange e-mails with MED-31 for approval in concept	MED-07 will receive task from MED-31, and will task a Res Unit	---	Reservist may obtain TCN
Rqmt Data Entry	MED-07 data entry and task to Res Unit	Fleet Hospital or MED-07 data entry and task to Res Unit	Direct data entry by Res Unit/RLO	Direct data entry by MED-07	Direct data entry by Res Unit/RLO	Direct data entry by Res Unit/RLO
Validation in Detail	MED-27	MED-27	MED-31	The justification should specify if RC not available, is command willing to pay for AC	MED-07	NR CO/RLO validation
Scanning for nominees	RLO recommend to NR CO/designee	RLO recommend to NR CO/designee	RLO recommend to NR CO/designee	---	RLO recommend to NR CO/designee	Comes Matched
Recruiting	NR CO is responsible, HQ staff and RLO to assist	NR CO is responsible, HQ staff and RLO to assist	NR CO is responsible, HQ staff and RLO to assist	If Res Unit can not fill, refer to MED-07	NR CO is responsible, HQ staff and RLO to assist	Comes Matched
Matching	NR CO is responsible, HQ staff and RLO to assist	NR CO is responsible, HQ staff and RLO to assist	NR CO is responsible, HQ staff and RLO to assist	Broker the retasking to another unit	NR CO is responsible, HQ staff and RLO to assist	Comes Matched
Issue BCN	RLO	RLO	RLO	---	RLO	Repeat TCN or give BCN

Enclosure (3)

BUMEDINST 1001.4
12 Jul 2002

WORKFLOW PROCESS FOR MEDRUPMIS

Classification Scheme for Requirements (classification identifies origination of need and authority for validation)

PROCESS	DENTAL SUPPORT TO BOOT CAMPS	DENTAL (NON-BOOT CAMP)
Rqmt Conceived	CO NR NDC HQ Unit obtains AT requests from ½ staff	MED-67 receives requirements from various sources
Pre-MEDRUP	Reservist contacts boot camp RLO for BCN	MED-67 and CO NR NDC HQ Unit plan
Rqmt Data Entry	Info copy of AT app to MED-67 for data entry	MED -67 translates requirements and performs data entry
Validation in Detail	MED-67 validates as data is entered	MED-67 validates as data is entered
Scanning for Nominees	Comes Matched	MED-67 review
Recruiting	Comes Matched	MED-67 recruits, may give "temp" BCN and refer reservist to active RLO
Matching	Comes Matched	---
Issue BCN	MED-67 inputs given BCN	Active RLO provide BCN to reservist and to MED-67